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Protection and Legal Liability of Electronic Medical Records in Primary Clinics from the Perspective of Legal Certainty

Novianti[1], Abdul Kolib[2], Handar Subhandi Bakhtiar[3]
[1,2,3] Universitas Pembangunan Nasional Veteran Jakarta, Indonesia
E-mail: noviantievi0708@gmail.com, kolib78@yahoo.com

*Correspondence: noviantievi0708@gmail.com

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ABSTRACT
One of the functions of Law Number 29 of 2004 concerning Medical Practice is the regulation of medical records. Along with the changing times, medical records have also developed into electronic medical records. Electronic medical records become a record of the patient's health during his life so that a need for protection and legal liability of electronic medical records at Pratama clinics. This study aims to analyze the law on the protection and legal liability of electronic medical records at Pratama clinics in terms of legal certainty perspective. This research uses normative empirical with a juridical normative research approach. Meanwhile, the research analysis is quantitative analysis. The results showed that medical records are regulated in Article 47 of the 2004 law on medical practice. Along with the development of technology comes Electronic Medical Records (RME) where documentation of patient medical records throughout life in electronic form. The implementation of electronic medical records in this Pratama clinic can provide better legal certainty for all parties involved in the health care process.

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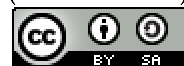

Introduction

Health is internationally recognized as one of the fundamental human rights that need to be upheld (Kolib, 2020a). Health is a critical element directly related to the quality of services (Bakhtiar, 2022). The provision of healthcare services must be carried out by ethical and morally upright doctors and dentists, and their fairness and credibility must be continuously enhanced (Ulumiyah, 2018).

As a nation that recognizes itself as a welfare state, Indonesia acknowledges the need for healthcare services for its citizens, based on Article 28H of the 1945 Constitution as the foundation of the Republic of Indonesia's Constitution (Kolib, 2021). The right to receive healthcare services is granted from the moment a person is in the womb (Bakhtiar & Syaid, 2022) This right is part of human basic rights, also known as human rights. Although this basic right has been recognized by various religions and has followed global developments, John Locke's name (1690) is noted in literature as the initiator of the fourth paragraph of the Preamble of the 1945 Constitution, which clearly states: "The

State protects all Indonesian citizens and the entire Indonesian bloodline," including the protection of rights in this sector. In 1960, the right to healthcare was officially recognized by Indonesian law. Article 1 of Law No. 9 of 1960 states: "Every citizen has the right to the highest possible degree of health and is obligated to participate in government efforts." This provision was updated in Article 4 of Law No. 23 of 1992, which states that "every person has an equal right to optimal health" (Marif et al., 2021). One of the key principles of a high-quality healthcare system is the availability of medical services provided by doctors and dentists that meet the requirements set by the Medical Practice Act No. 29 of 2004 (Hendrawan et al., 2021).

One of the functions regulated by Act No. 29 of 2004 on Medical Practice is the regulation of medical records, especially in Articles 46 and 47, which state that every doctor or dentist in medical practice is required to create medical records and must promptly complete them after a patient has received healthcare services (Mangentang, 2015). According to the Minister of Health through Health Minister Regulation No. 24 of 2022, Article 1 defines medical records as documents containing patient identification data, examinations, treatments, procedures, and other services provided to the patient (Indonesia, 2022). Electronic Medical Records (EMR) are medical records created using electronic systems designed for medical record management. Medical records can be used as written evidence in court (Nurfitria et al., 2022).

In Indonesia, the development of Electronic Medical Records (EMR) has been accompanied by the latest legislation, specifically the issuance of Law No. 17 of 2023 on Health, which requires healthcare facilities to implement EMRs in Chapter VI on Health Service Facilities, Section 1, Article 173, point C, stating that "Health Service Facilities are obligated to implement Electronic Medical Records." The Health Law, especially in Chapter Ten on Practice Organization, paragraphs 6, regulates Medical Records in Articles 296 through 300. The latest Minister of Health Regulation of the Republic of Indonesia on medical records, namely Health Minister Regulation No. 24 of 2022 on medical records, specifically in Chapter II, Section 1, Article 3, paragraph 1, states that "Every healthcare facility must implement electronic medical records." This was preceded by support from Law No. 8 of 1999 on Consumer Protection and Law No. 19 of 2016 on Information and Electronic Transactions (ITE Law), as well as Health Minister Regulation No. 269 of 2008 on the implementation of EMR as legal evidence, providing a bright outlook for EMR development in Indonesia (Kolib, 2020b).

The main issues and challenges in implementing medical records are related to the discipline and compliance of doctors, dentists, and healthcare personnel in filling and maintaining Electronic Medical Records. The Ministry of Health of Indonesia has issued guidelines for medical records, but a reference for medical records is still required for medical practice, considering the applicable legal aspects in both public and private general hospitals, special hospitals, and other individual healthcare services, such as in Primary Clinics. Medical records are crucial in analyzing a case as the primary evidence in legal cases.

Previous research by Kurniawan & Setiawan (2021) states that medical records belong to patients, which carry moral and legal consequences for healthcare providers who are also responsible for maintaining patient information within these records. Patient information must be safeguarded to prevent unauthorized and vested interests from using it without the patient's consent. The novelty in this research is explaining how legal accountability is applied in Electronic Medical Records.

The sophistication of information technology will not create sustainable competitive advantages without proper planning. Readiness analysis can be followed by strategic analysis to develop Electronic Medical Records as a planning tool to achieve competitive objectives. Recognizing the issues in various healthcare settings related to the provision of medical records and the development of electronic medical records as a means of legal protection for both healthcare providers and facilities from a legal certainty perspective, the researcher is interested in conducting research with the title "Protection and Legal Liability of Electronic Medical Records in Primary Clinics from the Perspective of Legal Certainty."

Research Methods

The research method used in this study is a normative research method with a type of empirical normative research (normative legal research), which is research that focuses on finding truth based on legal scientific logic from the normative side, in other words examining the application of norms in positive law, as a tool to solve legal problems in people's lives (Ibrahim, 2017).

The approach used is a juridical normative research approach. Meanwhile, the research analysis is a qualitative analysis that focuses on argumentation data and data sourced from literature studies.

Data sources that can be used in conducting legal research applicable at the Faculty of Law, Universitas Pembangunan Nasional Veteran Jakarta consist of secondary data, namely library data that includes official documents, publications about law.
The secondary data consists of:

1. Primary Legal Material consists of authoritative laws and regulations, namely:
   a. Constitution of 1945
   b. Law of the Republic of Indonesia Number 17 of 2023 concerning Health
   c. Law Number 8 of 1999 concerning Consumer Protection
   d. Law Number 19 of 2016 concerning Information and. Electronic Transactions (***ITE Law***)
   e. Permenkes RI Number 24 of 2022 concerning Medical Records
2. Secondary legal material is all publications about the law that are not official documents.

Tertiary legal materials in the form of internet sources, legal dictionaries or encyclopedia dictionaries or dictionaries Indonesian to explain the meaning or understanding of terms that are difficult to interpret.

Results and Discussions

An Electronic Medical Record (EMR) is electronic documentation that records a patient's health information throughout his or her life. This information is updated by health workers whenever a patient interacts with the health service, and these records are integrated into a single electronic system. Electronic medical records can be accessed through computers through networks with the main aim of providing or improving efficiency and integration of health care and services (Khasanah, 2020). Article 47 of 2004 concerning medical practice states that medical record documents belong to doctors, dentists, or health service facilities, while the contents of medical records belong to patients, which must be stored and maintained confidentially by all doctors and dentists and leaders of health service facilities (Suwignjo, 2019). One of the main problems in the

implementation of medical records is related to the discipline and compliance of medical personnel, including doctors, dentists, and other health workers, in filling and inputting electronic medical record data.

This discipline and compliance includes important aspects in maintaining the accuracy and completeness of patient medical data. Obstacles can arise if medical personnel do not routinely or correctly fill in patient data in the electronic medical record system. Errors or inconsistencies in data filling can interfere with the quality of available medical information, which in turn can affect a patient's treatment decisions and diagnosis. Therefore, it is important to address these challenges by involving proper training, close supervision, and building a strong awareness of the importance of discipline and compliance in electronic medical record management.

At this time, the Ministry of Health of the Republic of Indonesia has issued guidelines regulating medical records regulated in the regulation of the Minister of Health of the Republic of Indonesia number 24 of 2022 concerning medical records. The guidelines include procedures that medical personnel must follow in filling, managing, and maintaining patient medical records. The guidelines also cover issues of data security and patient privacy, as well as the standards that must be adhered to in the use of electronic medical records. This guideline aims to provide clear guidelines and frameworks in the management of medical records, including electronic medical records, in various health care facilities in Indonesia (Sylvia &; Maulana, 2023).

Even though medical record guidelines have been regulated, medical record references are still needed as a basis for carrying out medical practice that takes into account applicable legal aspects. This applies both to large health facilities such as public or private hospitals, special hospitals, and other individual health services, such as those manifested in Pratama Clinics. Pratama Clinic is a medical facility that provides basic medical services. In practice, this clinic provides a number of health services which include (Ministry of Health, 2023):

1. General practitioner consultation services.
2. General dentist consultation services.
3. Medical treatment services are simple.
4. Midwifery services are simple.
5. Medical records administration services.

Pratama Clinic functions as a community health service provider with a focus on basic care that includes medical consultation, dental care, simple medical procedures, and midwifery services. In addition, medical record administration services are also an integral part of patient management at this clinic. Medical record reference is important because it plays a role in:

1. Patient Monitoring

Medical records record the patient's medical history, diagnosis, treatment given, and development of health conditions. It helps doctors and medical teams to monitor and evaluate patient care on an ongoing basis.

2. Legal Certainty

Medical record documents also serve as legal evidence related to patient care. This is important to protect patients' rights and ensure that medical care is carried out in accordance with applicable regulations and standards.

3. Quality of Service

Medical records can be used as a tool to measure and improve the quality of health services. Data in medical records helps in research, analysis of health trends, and

identification of areas of improvement in health care.

4. Care Coordination

Medical record documents also play a role in coordinating patient care if a patient requires care from different health care providers or specialists.

Thus, even though primary clinics may be smaller health care facilities than large hospitals, medical records are still needed to ensure that the medical care provided is safe, effective, and in accordance with applicable legal standards. Medical records have a very important role in maintaining legal certainty in court cases. This document is the main evidence used to determine what happens to a patient during his medical treatment (Fatimah, 2017). Legal certainty means that every individual has the right to get medical treatment that is fair, safe, and in accordance with applicable standards (Hanifah, 2020). Medical records are a vital tool in ensuring that this right is respected.

In court cases, medical records can be strong evidence to determine whether the medical actions carried out are in accordance with applicable professional and legal standards. Medical records can also be used to prove medical negligence or improper conduct. Without accurate and detailed medical records, it will be difficult to achieve legal certainty in assessing legal liability in medical cases. In addition, legal certainty also means that all parties involved in court proceedings, including judges, lawyers, and juries, must be able to rely on the integrity and accuracy of these medical records (Fatimah, 2017). Therefore, it is important for the justice system to recognize the central role played by medical records in ensuring legal certainty and fairness in medical cases.

Pratama clinics have a legal responsibility to maintain the confidentiality and integrity of patients' electronic medical records. Primary clinics must also ensure that access to this data is restricted to authorized individuals only. Legal certainty also includes aspects of protection against hacking or data loss that can harm patients or health care providers. In addition, primary clinics need to understand that the use of electronic medical records can also be the basis of legal liability in malpractice cases. Therefore, correct and accurate use of electronic medical records can be a determining factor in avoiding unwanted lawsuits.

Legal accountability in electronic medical records at primary clinics includes a number of important aspects that must be followed to ensure legal certainty and patient protection. Here's how legal liability is applied in electronic medical records:

1. Responsibility for Data Accuracy

Pratama clinics have an obligation to ensure that the data recorded in electronic medical records is accurate and reliable. This includes checking the data entered by medical personnel, ensuring that medical records reflect the patient's state correctly, and conducting periodic verification of the information present in the system. Errors in medical records can result in legal consequences, such as malpractice charges.

2. Correct Data Handling

Primary clinics must follow the correct procedures in handling electronic medical record data. This includes securing data from unauthorized access, protecting data from potential damage or loss, and ensuring that only medical personnel have the right to access that data in accordance with applicable privacy regulations.

3. Patient Privacy Protection

Primary clinics have a legal responsibility to protect patient privacy. This includes ensuring that patient data is only accessed by authorized parties, and providing clear information to patients about how their data will be used. Violating patient privacy can

result in serious lawsuits.

4. Malpractice Prevention Efforts

Primary clinics should also take malpractice prevention measures. This includes ensuring that all medical personnel have adequate training, following correct procedures in patient care, and maintaining meticulous medical records. If there is any indication that malpractice has occurred, the primary clinic should take immediate action to deal with the problem.

5. Regulatory Compliance

Primary clinics must ensure that they comply with all applicable laws and regulations related to electronic medical records. This includes following guidelines from applicable health authorities and medical professional organizations.

The implementation of electronic medical records in primary clinics has a positive impact on legal certainty, which benefits patients and health care providers. With the adoption of this technology, primary clinics can ensure the integrity and accuracy of patient data in their medical records. This provides reassurance to patients that their information is well stored and can be accessed quickly and efficiently if needed in treatment or in legal cases. In addition, the use of electronic medical records can help primary clinics comply with strict data privacy regulations, thus protecting patients' privacy rights. It also increases transparency in patient data management, reduces the risk of errors or loss of information, and facilitates informed medical decision-making. Thus, the implementation of electronic medical records in primary clinics can provide better legal certainty for all parties involved in the health care process.

Conclusion

Based on the results of the study, it can be concluded that medical records have an important role and belong to patients. Health workers play a role in making and maintaining the confidentiality of medical records. This is regulated in Law Article 47 of 2004 concerning the practice of medicine. Along with the development of technology comes the Electronic Medical Record (RME) where the documentation of patient medical records throughout life in electronic form. The use of electronic medical records in primary clinics has a positive impact on legal certainty, which is beneficial for patients and healthcare providers thus providing reassurance to patients that their information is well stored and can be accessed quickly and efficiently if needed in treatment or in legal cases.

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